FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039230

Facility Name: OTTAWA PAVILION

Address: 800 E. CENTER ST. (Number) OTTAWA (City) 61350 (Zip Code)

County: LASALLE

Telephone Number: (847) 679-8219 **Fax #** (847) 679 - 7377

IDPA ID Number: 36-3919766001

Date of Initial License for Current Owners:

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA/PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1
(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

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Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	119	Skilled (SNF)	119	43,554	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,554	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,547	3,877	2,336	11,760	8
9	SNF/PED					9
10	ICF	18,683	6,043		24,726	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,230	9,920	2,336	36,486	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 83.77%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 2219

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number OTTAWA PAVILION # 0039230 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	174,525	22,377	4,630	201,532		201,532	0	201,532			1
2	Food Purchase		191,874		191,874	(25,199)	166,675	(5,006)	161,669			2
3	Housekeeping	124,599	22,464	0	147,063		147,063	0	147,063			3
4	Laundry	36,880	16,140	2,285	55,305		55,305	0	55,305			4
5	Heat and Other Utilities			91,127	91,127		91,127	518	91,645			5
6	Maintenance	54,958	28,142	14,690	97,790		97,790	7,919	105,709			6
7	Other (specify):*			5,089	5,089		5,089	433	5,522			7
8	**TOTAL General Services**	390,962	280,997	117,821	789,780	(25,199)	764,581	3,864	768,445			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000	0	6,000			9
10	Nursing and Medical Records	1,436,530	42,214	16,401	1,495,145		1,495,145	0	1,495,145			10
10a	Therapy	0	232	5,767	5,999		5,999	0	5,999			10a
11	Activities	80,343	5,178	2,470	87,991		87,991	0	87,991			11
12	Social Services	0		3,672	3,672		3,672	0	3,672			12
13	Nurse Aide Training			0				80	80			13
14	Program Transportation			0				0				14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	1,516,873	47,624	34,310	1,598,807		1,598,807	80	1,598,887			16
	C. General Administration											
17	Administrative	50,952		150,226	201,178		201,178	(14,848)	186,330			17
18	Directors Fees			0				0				18
19	Professional Services			26,026	26,026		26,026	3,326	29,352			19
20	Dues, Fees, Subscriptions & Promotions			30,418	30,418		30,418	(20,059)	10,359			20
21	Clerical & General Office Expense	54,304	20,691	150,652	225,647		225,647	(91,966)	133,681			21
22	Employee Benefits & Payroll Taxes			313,825	313,825	25,199	339,024	0	339,024			22
23	Inservice Training & Education			2,080	2,080		2,080	0	2,080			23
24	Travel and Seminar			0				419	419			24
25	Other Admin. Staff Transportation			3,981	3,981		3,981	19	4,000			25
26	Insurance-Prop.Liab.Malpractice			69,967	69,967		69,967	491	70,458			26
27	Other (specify):*			0				12,001	12,001			27
28	**TOTAL General Administration**	105,256	20,691	747,175	873,122	25,199	898,321	(110,617)	787,704			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,013,091	349,312	899,306	3,261,709		3,261,709	(106,673)	3,155,036			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			30,628	30,628		30,628	107,963	138,591			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			35,287	35,287		35,287	361,969	397,256			32
33	Real Estate Taxes			49,910	49,910		49,910	1,219	51,129			33
34	Rent-Facility & Grounds			438,000	438,000		438,000	(438,000)				34
35	Rent-Equipment & Vehicles			14,164	14,164		14,164	5,073	19,237			35
36	Other (specify):*							0				36
37	TOTAL Ownership			567,989	567,989		567,989	38,224	606,213			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		44,408	90,704	135,112		135,112	(453)	134,659			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			65,332	65,332		65,332	0	65,332			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		44,408	156,036	200,444		200,444	(453)	199,991			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,013,091	393,720	1,623,331	4,030,142	0	4,030,142	(68,902)	3,961,240			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(47,614)	30		9
10	Interest and Other Investment Income	(55)	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,011)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(995)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(144)	20		17
18	Fines and Penalties	(2,958)	21		18
19	Entertainment	0	20		19
20	Contributions	(200)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(20,239)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	2,463	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (73,753)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	4,851		34
35	Other- Attach Schedule	0		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 4,851		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (68,902)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Previe

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.
The amounts in columns F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.
1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name OTTAWA PAVILION
ID# 0029220
Report Period Beginning: 01/01/2009
Ending: 12/31/2009

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
The information listed in B13 thru G43 is from Page 5.					
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(5,986)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	2	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0
6	**Rented Facility Space**	0	34	**Line 6**	2,483
7	**Sale of Supplies to Non-Patients**	0	10	**Line 7**	0
8	**Laundry for Non-Patients**	0	4	**Line 8**	(2,547)
9	**Non-Straightline Depreciation**	(47,614)	30	**Line 9**	0
10	**Interest and Other Investment Income**	(55)	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	(4,011)	2	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(995)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 15**	0
17	**Non-Care Related Fees**	(144)	20	**Line 16**	0
18	**Fines and Penalties**	(2,958)	21	**Line 17**	0
19	**Entertainment**	0	20	**Line 18**	0
20	**Contributions**	(200)	20	**Line 19**	0
21	**Owner or Key-Man Insurance**	0	22	**Line 20**	(26,181)
22	**Special Legal Fees & Legal Retainers**	0	19	**Line 21**	(5,955)
23	**Malpractice Insurance for Individuals**	0	26	**Line 22**	0
24	**Bad Debt**	0	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(20,239)	20	**Line 24**	0
26	**Income & IL Personal Property Replacement T**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 26**	0
28	**Yellow Page Advertising**	0	20	**Line 27**	0
29	**Non-Paid Workers**	0	0	**Line 28**	(23,541)
30	**Donated Goods**	0	0	**Line 29**	(26,986)
31	**Amortization Expense**	0	0	**Line 30**	(47,614)
32	DEFERRED MAINTENANCE	2,463	6	**Line 31**	0
33				**Line 32**	(55)
34				**Line 33**	0
35				**Line 34**	0
36				**Line 35**	0
37				**Line 36**	0
38				**Line 37**	(47,669)
39				**Line 38**	0
40				**Line 39**	0
41				**Line 40**	32
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(73,719)

Print Other Adjustment

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,006)	0	0	0	0	0	0	0	0	0	0	(5,006)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	518	0	0	0	0	0	0	0	0	518	5
6	Maintenance	2,463	0	2,648	2,808	0	0	0	0	0	0	0	7,919	6
7	Other (specify):*	0	0	75	0	358	0	0	0	0	0	0	433	7
8	**TOTAL General Services**	(2,543)	0	3,241	2,808	358	0	0	0	0	0	0	3,864	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	80	0	0	0	0	0	0	0	0	80	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	0	80	0	0	0	0	0	0	0	0	80	16
	C. General Administration													
17	Administrative	0	(150,226)	0	135,378	0	0	0	0	0	0	0	(14,848)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,075	1,251	0	0	0	0	0	0	0	0	3,326	19
20	Fees, Subscriptions & Promotions	(20,583)	0	524	0	0	0	0	0	0	0	0	(20,059)	20
21	Clerical & General Office Expenses	(2,958)	(122,945)	31,309	2,628	0	0	0	0	0	0	0	(91,966)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	419	0	0	0	0	0	0	0	0	419	24
25	Other Admin. Staff Transportation	0	0	19	0	0	0	0	0	0	0	0	19	25
26	Insurance-Prop.Liab.Malpractice	0	0	491	0	0	0	0	0	0	0	0	491	26
27	Other (specify):*	0	0	4,150	0	7,851	0	0	0	0	0	0	12,001	27
28	**TOTAL General Administration**	(23,541)	(271,096)	38,163	138,006	7,851	0	0	0	0	0	0	(110,617)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(26,084)	(271,096)	41,484	140,814	8,209	0	0	0	0	0	0	(106,673)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(47,614)	153,409	2,168	0	0	0	0	0	0	0	0	107,963	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(55)	360,457	1,567	0	0	0	0	0	0	0	0	361,969	32
33	Real Estate Taxes	0	0	1,219	0	0	0	0	0	0	0	0	1,219	33
34	Rent-Facility & Grounds	0	(438,000)	0	0	0	0	0	0	0	0	0	(438,000)	34
35	Rent-Equipment & Vehicles	0	0	5,073	0	0	0	0	0	0	0	0	5,073	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(47,669)	75,866	10,027	0	0	0	0	0	0	0	0	38,224	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(453)	0	0	0	0	0	(453)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	(453)	0	0	0	0	0	(453)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(73,753)	(195,230)	51,511	140,814	8,209	(453)	0	0	0	0	0	(68,902)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe OTTAWA PAVILION # 0039230 Report Period Beginning 01/01/2000 Ending 12/31/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V	17 MANAGEMENT FEES	$ 150,226	DYNAMIC HEALTHCARE CONSULTANT	%	$	$ (150,226)	1	-150226
2	V	21 BUOKKEEPING FEES	122,945	" " "			(122,945)	2	-122945
3	V							3	
4	V							4	
5	V							5	
6	V							6	
7	V							7	
8	V							8	
9	V							9	
10	V	24 RENT	438,000	OTTAWA PAVILION BUILDING LLC			(438,000)	10	-438000
11	V	30 DEPRECIATION		" " "		153,409	153,409	11	153409
12	V	22 INTEREST		" " "		360,457	360,457	12	360457
13	V	19 PROFESSIONAL FEES		" " "		2,078	2,078	13	2075
14	Total		$ 711,171			$ 515,944	$ * (195,226)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 518	$ 518	15	518
16	V	6	REPAIRS & MAINT.		" " "	100.00%	2,648	2,648	16	2648
17	V	7	EMP. BEN. - GEN. SERVICES		" " "	100.00%	75	75	17	75
18	V	13	NURSES AIDE TRAINING		" " "	100.00%	80	80	18	80
19	V	19	PROFESSIONAL FEES		" " "	100.00%	1,251	1,251	19	1251
20	V	20	DUES AND SUBSCRIPTION		" " "	100.00%	524	524	20	524
21	V	21	CLERICAL & GENERAL		" " "	100.00%	31,309	31,309	21	31309
22	V	24	SEMINARS AND TRAVEL		" " "	100.00%	419	419	22	419
23	V	25	ADMIN. STAFF TRANS		" " "	100.00%	19	19	23	19
24	V	26	INSURANCE		" " "	100.00%	491	491	24	491
25	V	27	EMP BEN. - GEN ADMIN.		" " "	100.00%	4,150	4,150	25	4150
26	V	30	DEPRECIATION		" " "	100.00%	2,168	2,168	26	2168
27	V	32	INTEREST		" " "	100.00%	1,567	1,567	27	1567
28	V	33	REAL ESTATE TAXES		" " "	100.00%	1,219	1,219	28	1219
29	V	35	EQUIPMENT RENTAL		" " "	100.00%	5,073	5,073	29	5073
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 51,511	$ * 51,511	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6B
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 2,808	$ 2,808	15	2808
16	V	10	NURSING CMP - SUE G.		" " "	100.00%			16	
17	V	17	ADMIN. CMP. - M. MAUER		" " "	100.00%	22,664	22,664	17	22664
18	V	17	ADMIN. CMP. - M. AARON		" " "	100.00%	29,031	29,031	18	29031
19	V	17	ADMIN. CMP. - F. AARON		" " "	100.00%			19	
20	V	17	ADMIN. CMP. - A. STERN		" " "	100.00%	18,313	18,313	20	18313
21	V	17	ADMIN. CMP. - S. GOLDSTEIN		" " "	100.00%			21	
22	V	17	ADMIN. CMP. - S. KOPLIN		" " "	100.00%	5,343	5,343	22	5343
23	V	17	ADMIN. CMP. - D. MAGAFAS		" " "	100.00%			23	
24	V	17	ADMIN. CMP. - E. CASSON		" " "	100.00%			24	
25	V	17	ADMIN. CMP. - S. BOGEN		" " "	100.00%	41,983	41,983	25	41983
26	V	17	ADMIN. CMP. - S. LEVY		" " "	100.00%	6,612	6,612	26	6612
27	V	17	ADMIN. CMP. - A. STEINER		" " "	100.00%	2,159	2,159	27	2159
28	V	17	ADMIN. CMP. - NON-OWNER		" " "	100.00%	9,273	9,273	28	9273
29	V	21	CLERICAL CMP. - S. AARON		" " "	100.00%	2,628	2,628	29	2628
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 140,814	$ * 140,814	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Print Page 6

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STATE OF ILLINOIS

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6C
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 358	$ 358	15	358
16	V	15	EMP. BEN. - SUE G.		" " "	100.00%			16	
17	V	27	EMP. BEN. - M. MAUER		" " "	100.00%	633	633	17	633
18	V	27	EMP. BEN. - M. AARON		" " "	100.00%	736	736	18	736
19	V	27	EMP. BEN. - F. AARON		" " "	100.00%			19	
20	V	27	EMP. BEN. - S. GOLDSTEIN		" " "	100.00%			20	
21	V	27	EMP. BEN. - S. KOPLIN		" " "	100.00%	1,138	1,138	21	1138
22	V	27	EMP. BEN. - D. MAGAFAS		" " "	100.00%			22	
23	V	27	EMP. BEN. - E. CASSON		" " "	100.00%			23	
24	V	27	EMP. BEN. - S. BOGEN		" " "	100.00%	2,473	2,473	24	2473
25	V	27	EMP. BEN. - S. LEVY		" " "	100.00%	906	906	25	906
26	V	27	EMP. BEN. - A. STEINER		" " "	100.00%	358	358	26	358
27	V	27	EMP. BEN. - NON-OWNER		" " "	100.00%	1,247	1,247	27	1247
28	V	27	EMP. BEN. - S. AARON		" " "	100.00%	360	360	28	360
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 8,209	$ * 8,209	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		10a	THERAPY	$ 5,766	DYNAMIC REHAB CONSULTANTS LLC		$ 5,766	$	15
16	V		22	EMPLOYEE BENEFITS	(5,368)	" " "		(5,368)		16
17	V		39	ANCILLARY SERVICES	88,288	" " "		88,288		17
18	V									18
19	V									19
20	V		10	NURSING & MEDICAL SUPP	8,245	PHARMCOR LLC		8,245		20
21	V		11	ACTIVITIES		" "				21
22	V		22	EMPLOYEE BENEFITS	1,362	" "		1,362		22
23	V		39	ANCILLARY EXPENSE	40,167	" "		40,167		23
24	V									24
25	V									25
26	V		20	DUES, FEES & SUBSCRIPTION		LINCOLN MEDICAL SUPPLIES, INC.				26
27	V		10	MEDICAL SUPPLIES		" " "				27
28	V		39	ANCILLARY EXPENSE	1,722	" " "		1,269	(453)	28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 140,182			$ 139,729	$ * (453)	39

Sum_6D

-453

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	MAURY AARON		ADMINISTRATIVE			SCHEDULE ATTACHI		SALARY	$ 29,031	17-7	1
2	ABE STERN		ADMINISTRATIVE					CONSLT FEE	18,313	17-7	2
3	MARSHALL MAUER		ADMINISTRATIVE					SALARY	22,664	17-7	3
4	SHEILA BOGEN		ADMINISTRATIVE					SALARY	41,983	17-7	4
5	SHARON AARON		CLERICAL					SALARY	2,628	21-7	5
6											6
7			SCHEDULE								7
8			ATTACHED								8
9											9
10											10
11											11
12											12
13								TOTAL	$ 114,619		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Previe

the name(s)
PORTS.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT C... [Show Pgs 8A thru 8] [Show Pgs 8E thru 8] [Hide Pgs 8A thru 8]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: DYNAMIC HEALTHCARE CONSULT
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 679-8219
Fax Number: ((847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	707,726	15	$ 10,055	$	36,486	$ 518	1
2	6	REPAIRS & MAINT	" "	707,726	15	51,362	16,071	36,486	2,648	2
3	7	EMP. BEN. - GEN. SVC.	" "	707,726	15	1,448		36,486	75	3
4	13	NURSES AIDE TRAINING	" "	707,726	15	1,550		36,486	80	4
5	19	PROFESSIONAL FEES	" "	707,726	15	24,272		36,486	1,251	5
6	20	DUES & SUBSCRIPTIONS	" "	707,726	15	10,163		36,486	524	6
7	21	CLERICAL & GENERAL	" "	707,726	15	607,305	465,093	36,486	31,309	7
8	24	SEMINARS & TRAVEL	" "	707,726	15	8,134		36,486	419	8
9	25	ADMIN. STAFF TRANS.	" "	707,726	15	372		36,486	19	9
10	26	INSURANCE	" "	707,726	15	9,517		36,486	491	10
11	27	EMP.BEN. - GEN. ADMIN.	" "	707,726	15	80,498		36,486	4,150	11
12	30	DEPRECIATION	" "	707,726	15	42,057		36,486	2,168	12
13	32	INTEREST	" "	707,726	15	30,386		36,486	1,567	13
14	33	REAL ESTATE TAXES	" "	707,726	15	23,654		36,486	1,219	14
15	35	EQUIPMENT RENTAL	" "	707,726	15	98,401		36,486	5,073	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 999,174	$ 481,164		$ 51,511	25

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Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: DYNAMIC HEALTHCARE CONSULT
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 679-8219
Fax Number: ((847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	14	$ 54,000	$ 54,000	2	$ 2,808	1
2	10	NURSING - SUE G.	" "	40	1	32,209	32,209		0	2
3	17	ADMIN. CMP. - M. MAUER	" "	40	14	435,842	435,842	2	22,664	3
4	17	ADMIN. CMP. - M. AARON	" "	45	14	558,156	558,156	2	29,031	4
5	17	ADMIN. CMP. - F. AARON	" "	50	7	160,040	160,040		0	5
6	17	ADMIN. CMP. - A. STERN	" "	8	14	351,664		0	18,313	6
7	17	ADMIN. CMP. - S. GOLDST	" "	50	3	179,079	179,079		0	7
8	17	ADMIN. CMP. - S. KOPLIN	" "	45	10	67,732	67,732	4	5,343	8
9	17	ADMIN. CMP. - D. MAGAFA	" "	45	10	82,127	82,127		0	9
10	17	ADMIN. CMP. - E. CASSON	" "	45	2	47,882	47,882		0	10
11	17	ADMIN. CMP. - S. BOGEN	" "	45	3	119,320	119,320	16	41,983	11
12	17	ADMIN. CMP. - S. LEVY	" "	55	14	126,974	126,974	3	6,612	12
13	17	ADMIN. CMP. - A. STEINER	" "	45	14	41,511	41,511	2	2,159	13
14	17	ADMIN. CMP. - NON-OWNI	" "	45	14	178,292	178,292	2	9,273	14
15	21	CLERICAL CMP. - S. AARO	" "	40	14	50,548	50,548	2	2,628	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,485,376	$ 2,133,712		$ 140,814	25

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STATE OF ILLINOIS

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: DYNAMIC HEALTHCARE CONSULT
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 679-8219
Fax Number: ((847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP BEN - D. NEHMER	WGHTD. AVG. HOURS	40	14	$ 6,887	$	2	$ 358	1
2	15	EMP BEN - SUE G.	" "	40	1	2,883			0	2
3	27	EMP BEN - M. MAUER	" "	40	14	12,175		2	633	3
4	27	EMP BEN - M. AARON	" "	45	14	14,155		2	736	4
5	27	EMP BEN - F. AARON	" "	50	7	19,744			0	5
6	27	EMP BEN - S. GOLDSTEIN	" "	50	3	18,514			0	6
7	27	EMP BEN - S. KOPLIN	" "	45	10	14,423		4	1,138	7
8	27	EMP BEN - D. MAGAFAS	" "	45	10	13,516			0	8
9	27	EMP BEN - E. CASSON	" "	45	2	10,284			0	9
10	27	EMP.BEN. - S. BOGEN	" "	45	3	7,029		16	2,473	10
11	27	EMP BEN - S. LEVY	" "	55	14	17,400		3	906	11
12	27	EMP BEN - A. STEINER	" "	45	14	6,891		2	358	12
13	27	EMP BEN - NON-OWNER	" "	45	14	23,984		2	1,247	13
14	27	EMP BEN - S. AARON	" "	40	14	6,917		2	360	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 174,802	$		$ 8,209	25

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STATE OF ILLINOIS

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: DYNAMIC REHAB CONSULTANTS L
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 679-8219
Fax Number: ((847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION						5,766	2
3	22	EMPLOYEE BENEFITS	" "						(5,368)	3
4	39	ANCILLARY SERVICES	" "						88,288	4
5										5
6										6
7		PHARCOR LLC								7
8	10	NURSING & MEDICAL SUP	DIRECT ALLOCATION						8,245	8
9	22	EMPLOYEE BENEFIT	" "						1,362	9
10	39	ANCILLARY EXPENSE	" "						40,167	10
11										11
12										12
13		LINCOLN MEDICAL SUPPLIES								13
14	20	DUES, FEES & SUBSCRIPT	DIRECT ALLOCATION							14
15	10	MEDICAL SUPPLIES	" "							15
16	39	ANCILLARY EXPENSE	" "						1,269	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 139,729	25

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STATE OF ILLINOIS

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: PHARMOR, LLC
Street Address: 3116 S. OAK PARK
City / State / Zip Code: BERWYN, IL 60402
Phone Number: (708) 795-7701
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HAJEK/REICHERT		X	MORTGAGE	$36,043.00	12/1/98	$ 3,800,000	$ 3,663,658	11/1/18	9.75	$ 360,457	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MANUFACTURERS BANK		X	WORKING CAPITAL				425,000		PRIME+	35,287	6
7												7
8	RELATED PARTY	X									1,567	8
9	TOTAL Facility Related				$36,043.00		$ 3,800,000	$ 4,088,658			$ 397,311	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,800,000	$ 4,088,658			$ 397,311	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Numbe OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	51,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	49,910	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,090)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	51,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	49,910	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	45,546	8
	1996	47,595	9
	1997	49,954	10
	1998	50,028	11
	1999	49,910	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Numb OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,128 B. General Construction Type: Exterior _____ Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	0	1998	$ 400,000	1
2					2
3	TOTALS			$ 400,000	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	119		1998		$ 3,243,000	$ 83,151	39	$ 83,151	$	$ 169,772	4
5											5
6											6
7											7
8					22,869	586	35	653	67	4,792	8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	LEASEHOLD IMPROVEMENT			1994	13,015	333	39	333		2,144	9
10	WALLPAPER			1995	18,314	470	39	470		2,463	10
11	DRYWALL IN CORRIDOR			1995	17,550	450	39	450		2,381	11
12	HANDRAILS			1995	7,839	201	39	201		1,047	12
13	SECURITY DOOR			1995	1,602	41	39	41		207	13
14	MIXING VALVE & WATER HEATER			1995	756	19	39	19		96	14
15	HANDRAIL & BUMPER			1996	6,895	177	39	177		878	15
16	HANDRAIL & BUMPER			1996	721	18	39	18		84	16
17	ALARM			1996	1,146	29	39	29		128	17
18	PANIC DEVICE			1996	1,550	40	39	40		168	18
19	REPLACE RECONNECT SWITCH & STARTER			1996	1,074	28	39	28		115	19
20	DRAPERIES			1996	13,334	342	39	342		1,382	20
21	DRAPERY, CARPETING			1997	12,786	328	39	328		1,054	21
22	PIPING WORK, HEAT/COOL UNITS			1997	4,341	111	39	111		361	22
23	HEAT/COOL UNITS			1998	4,732	131	39	131		331	23
24	OFFICE REMODELING			1998	1,475	38	39	38		97	24
25	SHELVING/COOLER			1998	1,493	28	39	28		79	25
26	BOILER, HEAT/COOL UNIT			1999	10,441	268	39	268		505	26
27	ALARM SYSTEM			1999	2,853	73	39	73		143	27
28	WINDOWS			1999	19,785	507	39	507		809	28
29	FOLDING STEEL GATE			1999	884	23	39	23		24	29
30	REMODELING DISHWASHER ROOM			1999	5,000	128	39	128		133	30
31	DRAPERIES			1999	6,439	165	39	165		199	31
32	PARKING LOT PAVING			1999	1,834	47	39	47		74	32
33	BASEMENT REMODEL			2000	15,203	190	27.5	190		190	33
34	WINDOW REPAIR -- DOOR			2000	3,026	37	27.5	37		37	34
35	FEED PUMP -- HOT WATER VALVE			2000	4,131	53	27.5	53		53	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 88,012		$ 88,079	$ 67	$ 189,746	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	SPRINKLER SYSTEM REPAIR			2000	1,175	15	27.5	15		15	9
10	AIR CONDITIONER			2000	1,273	16	27.5	16		16	10
11	CARPETING -- SHEERS			2000	5,693	814	20	142	(672)	142	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
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23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 845		$ 173	$ (672)	$ 173	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Facility Name & ID Numbe OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 134,799	$ 23,045	$ 12,800	$ (10,245)	10-20 YRS	$ 43,550	37
38	Current Year Purchases	17,235	2,463	431	(2,032)	10 YRS	431	38
39	Fully Depreciated Assets							39
40	RELATED PARTY	370,405	71,682	36,971	(34,711)	10 YRS	152,790	40
41	TOTALS	$ 522,439	$ 97,190	$ 50,202	$ (46,988)		$ 196,771	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	RELATED PARTY			$ 820	$ 158	$ 137	$ (21)		$ 137	42
43										43
44										44
45										45
46	TOTALS			$ 820	$ 158	$ 137	$ (21)		$ 137	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 186,205	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 138,591	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (47,614)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 386,827	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____ This amount was calculated by dividing the total amount to be amortized _____ by the length of the lease _____.

9. Option to Buy: [ ] YES [ ] NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipm $ 7,264 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTR	VAN	$ 575.00	$ 6,900	17
18					18
19					19
20					20
21	TOTAL		$ 575.00	$ 6,900	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ___

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Cost	Outside Practitioner (other than consultant) Units	Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs		$		$ 39,095	$		$ 39,095	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				8,891			8,891	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				40,303			40,303	4
5	Physician Care	39-3	visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					42,700		42,700	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	LABORATORY Other (specify):						2,415	1,708		4,123	13
14	TOTAL				$		$ 90,704	$ 44,408		$ 135,112	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	448,516		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,581		6
7	Other Prepaid Expenses	2,341		7
8	Accounts Receivable (owners or related parties)	189,832		8
9	Other(specify): RE ESCROW	51,346		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 721,616	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	186,360		15
16	Equipment, at Historical Cost	152,034		16
17	Accumulated Depreciation (book methods)	(109,632)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	13,236		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(13,236)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	360		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 229,122	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 950,738	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 258,147	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	497,893		29
30	Accrued Salaries Payable	159,286		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,204		31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,000		32
33	Accrued Interest Payable	1,795		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 974,325	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 974,325	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (23,587)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 950,738	$	48

*(See instructions.)

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Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 164,994	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 164,994	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(188,581)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (188,581)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (23,587)	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,782,352	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,782,352	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	55,143	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 55,143	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	55	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 55	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	DISCOUNTS	4,011	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,011	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 3,841,561	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 789,780	31
32	Health Care	1,598,807	32
33	General Administration	873,122	33
	B. Capital Expense		
34	Ownership	567,989	34
	C. Ancillary Expense		
35	Special Cost Centers	135,112	35
36	Provider Participation Fee	65,332	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,030,142	40
41	**Income before Income Taxes (line 30 minus line 40)****	(188,581)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ (188,581)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,030	1,220	$ 25,062	$ 20.54	1
2	Assistant Director of Nursing	3,058	3,446	63,757	18.50	2
3	Registered Nurses	24,500	25,243	467,220	18.51	3
4	Licensed Practical Nurses	7,404	7,920	119,491	15.09	4
5	Nurse Aides & Orderlies	71,130	75,801	700,096	9.24	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,950	2,273	24,297	10.69	9
10	Activity Assistants	8,352	8,770	56,046	6.39	10
11	Social Service Workers					11
12	Dietician	2,046	2,328	31,942	13.72	12
13	Food Service Supervisor					13
14	Head Cook	953	1,009	7,772	7.70	14
15	Cook Helpers/Assistants	17,847	19,263	134,811	7.00	15
16	Dishwashers					16
17	Maintenance Workers	6,305	6,595	54,958	8.33	17
18	Housekeepers	17,679	19,348	124,599	6.44	18
19	Laundry	5,788	5,847	36,880	6.31	19
20	Administrator	2,006	2,276	50,952	22.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,350	4,599	54,304	11.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,084	2,253	20,171	8.95	31
32	Other Health Care(specify)					32
33	Other(specify PSYCHO SOCI	4,557	4,891	40,733	8.33	33
34	TOTAL (lines 1 - 33)	181,039	193,082	$ 2,013,091 *	$ 10.43	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	160	$ 4,044	1-3	35
36	Medical Director	MONTHLY	6,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	96	1,800	10-3	39
40	Physical Therapy Consultant	50	1,759	10a-3	40
41	Occupational Therapy Consulta	115	4,008	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	57	2,470	11-3	44
45	Social Service Consultant	68	3,672	12-3	45
46	Other(specify)				46
47	PSYCHIATRIC	53	2,057	10-3	47
48					48
49	TOTAL (lines 35 - 48)	599	$ 25,810		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides	703	12,544	10-3	52
53	TOTAL (lines 50 - 52)	703	$ 12,544		53